STATE OF VERMONT

HUMAN SERVICES BOARD

In re) Fair Hearing No. 12,180

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Appeal of)

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INTRODUCTION

The petitioner appeals a decision of the Department of Social Welfare denying his request to authorize an exception for payment of dentures through the Medicaid program.

FINDINGS OF FACT

1. The petitioner is a thirty-eight year old disabled Social Security and Medicaid recipient who had surgery last January to remove his colon as treatment for ulcerative colitis. The petitioner wears an ileostomy bag externally which he hopes will be replaced later in the year by an internal bag. Subsequent to his January surgery, he has been hospitalized on at least one occasion for complications. His treatment for his bowel disease has been covered under the Medicaid program.

2. The petitioner has no lower teeth. His upper teeth were replaced with dentures due to an accident he had at the age of sixteen. Due to the lack of lower teeth, the petitioner is unable to grind food and for this reason cannot eat whole fruits, vegetables, grains or seeds. He purees and grinds many foods but is unable to do so when he is not at home.

3. Shortly after his surgery, in order to further the treatment of his bowel disease, the petitioner, on the advice of his physician, applied for payment of dentures through the Medicaid program. In support of his application, he provided a note dated March 29, 1993 from his local treating physician stating that "[petitioner] suffers from chronic ulcerative colitis and needs to follow a specific diet; therefore, dentures are necessary for optimum control of his disease." On April 29, 1993, his physician wrote a similar letter stating "[petitioner] has had recent surgery for chronic ulcerative colitis; he needs to follow a specific diet for optimum control of his disease. He is finding this difficult without dentures. Please consider Medicaid coverage for dentures."

4. The petitioner's request for an exception to cover dentures was denied in May of 1993. That decision

was reviewed by the Commissioner on August 30, 1993 and the denial was upheld because "Dentures are not a covered item for individuals over age 21."

5. The petitioner appealed the Department's decision in July. In August, the petitioner was hospitalized for pain and vomiting resulting from an obstruction in his small intestine which may have been caused by a large food particle.

6. Subsequent to his appeal, the petitioner provided two further medical opinions in support of his claim. The first was yet another letter, this one dated August 30, 1993, from his treating physician which stated that "[petitioner] has had a colectomy for ulcerative colitis and requires dentures to assure adequate functioning of his ileostomy." The second is a letter dated August 25, 1993 from the petitioner's treating gastroenterologist which is attached hereto and incorporated in its entirety herein as Exhibit Number One.

7. Based on the above uncontradicted medical evidence, it is found that the acquisition of dentures is a medically necessary component of successful treatment of the petitioner's inflammatory bowel disease.

ORDER

The Department's decision is reversed.

REASONS

The Department's Medicaid regulations generally provide for the payment of items and services which are reasonable and necessary for the treatment or diagnosis of illness or injury or to improve the functioning of a malformed body member excluding only those items which do not meet the above test, or which are specifically excluded under the regulations for other reasons. See M152.1, M511, and M613-618. Under the regulations, payment for items and services related to the treatment of ulcerative colitis are not prohibited and, indeed, it appears that the Department has paid for all other treatment the petitioner has received for this condition.

However, the Department takes the position that it is prevented under its regulations governing the provision of dental services from providing one specific treatment, namely dentures, for the petitioner, even if they are medically necessary for the treatment of the petitioner's ulcerative colitis.[(1)] The text of the regulation relied on by the Department is as follows:

Dental Services for Recipients Age 21 and older

Effective January 1, 1989, coverage of dental services is extended to recipients age 21 and older. The scope of the program includes emergency dental care for relief of pain, bleeding and infection, selected preventive and restorative procedures rendered to limit disease progression, and necessary diagnostic and consultative services.

Covered services include:

o Oral examinations - including oral cancer screenings

o Diagnostic care services - radiography and related testing

o Preventive/Restorative care - limited to oral prophylaxis, root planing and scaling, amalgam and composite restorations, and placement of prefabricated crowns.

o Endodontia - not to exceed three teeth treated per person

o Oral surgery - all necessary surgery for tooth removal, and palliative treatment, such as abscess drainage. Third molar surgery will initially require authorization prior to treatment.

Rehabilitative, cosmetic, or elective procedures are not covered. Services not covered include:

o Cosmetic dentistry

o Bonding

o Sealants

o Periodontal surgery

o Non-surgical, comprehensive/periodontal care

o Orthodontia

o Crown and bridge

o Dentures (full and partial)

o Elective care

Other program limits include:

o Annual benefit maximum $500 per person

o Services:

limits same as in M620

o Prior Authorization:

a complete list of procedures which require prior authorization is available from the Medicaid fiscal agent upon request.

o Procedure Review:

all services reviewed during post-audit for appropriateness.

M621

Not only does the Department view the above regulation as preventing it from providing coverage of dentures to treat the petitioner's ulcerative colitis but also takes the position that it prevents the Department from ever paying for dentures in any circumstance with the exception of temporomandibular joint dysfunction treatment or, possibly, in the treatment of a "life-threatening" circumstance. The Department makes no attempt to explain what language in the regulations would authorize an exception to its interpretation of the sweeping prohibition it claims exists in the plain language of the regulation. The Department's memorandum suggests that the TMJ exception is made only because the Board has made such an order in the past which order is limited solely, in the Department's view, to persons with that disease; the "life-threatening" exception would presumably be made on some humanitarian, rather than legal grounds.

The petitioner, surprisingly, does not appear to disagree with the Department's interpretation of the above regulation as an ironclad prohibition against payment for dentures for any reason. His argument is that the entire regulation cited above should be declared invalid as an unconstitutional and unlawful attempt by the state to narrow services to persons based on their diagnosis in violation of federal and state Medicaid regulations.

What neither party seems to recognize is that this is not really a case of first impression before the Board and that issues raised by this appeal have been analyzed and answered at least by implications in at least three prior decisions. See Fair Hearings No. 10,379, 11,207, and 11,625. The parties have made no argument that the reasoning implied in those decisions, which involved treatment of temporomandibular joint dysfunction, should or should not be followed or that the reasoning is or is not adequate to address the problem presented in this appeal, without reaching questions of the validity of the state's regulations.

The reasoning in the prior decisions, while not delineated at length in the texts, is unmistakably implied in the analyses. Those analyses can be best stated is as follows: The clear meaning of the language in the regulation cited above at M621 concerning dental care imposes an absolute prohibition on payment for dentures when the sole purpose is for rehabilitative or cosmetic purposes. However, there is nothing in M621 or any other Medicaid regulation which prohibits payment for dentures when such an item is medically necessary to treat another illness or injury which is covered by Medicaid. And this is true even though a by-product of the treatment may be the rehabilitation or cosmetic improvement of the recipient's dentition so long as the purpose of the procedure was to provide necessary treatment of a clearly covered illness or injury.

The above interpretation reflects the plain meaning of the language used in this regulation which, as a whole, addresses only dental care, and, in the specific subsection at issue, addresses only rehabilitative, cosmetic and elective care. It makes no sense linguistically to take the prohibition in a dental care regulation and apply it generally across the Board to other regulations governing

treatment in medical (as opposed to dental) cases, absent specific language directing this result.

The above interpretation also preserves the stated goal of the Medicaid program which is to cover "most,

but not all, medically necessary medical care and services provided to eligible individuals."(2) There is nothing in the regulations governing medical care which indicates a goal of restricting necessary services for medical illness and injury just because the service may incidentally involve the patient's dentition. In fact, there is at least one regulation which, completely contrary to the Department's argument, specifically provides for payment of inpatient hospital services for adult patients for any kind of dental procedure when needed "to assure proper medical management or control of non-dental impairment." See M512(3). There is no reason to suppose that less would be required for patients treated outside hospitals, absent a regulation specifically prohibiting such provision.

The Department's regulation on dental care clearly expresses a desire to exclude Medicaid coverage for dentures in the vast majority of cases where dentures are rehabilitative or cosmetic and are not necessary for the treatment of another covered illness or injury. The interpretation consistently put forth by the Board in its denture exception cases and more fully delineated herein, preserves this clearly stated prohibition. As this prohibition now stands, persons who request payment for dentures who cannot show a real medical necessity for treatment of an illness or injury (other than the obvious improvement in health which any human being would experience with full and healthy dentition) are simply going to be denied. Whether this prohibition is illegal and unconstitutional, as the petitioner asserts, is a question which need not be reached here because the petitioner has shown that his request is not merely rehabilitative or cosmetic but the result of a real medical need in the treatment of a covered illness. The regulation at M621 cannot operate, therefore, to deny payment for dentures requested by him.

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1. The Department in its memorandum indicates that it does not agree that dentures are medically necessary for the treatment of the petitioner's ulcerative colitis. However, the Department has presented no medical evidence whatsoever in support of its position. In light of the fact that the sole expert opinion in this matter indicates unequivocally that dentures are medically necessary in the treatment of the petitioner's disease, that fact must be taken as undisputed in the evidence.

2. The regulations cited in the first paragraph of this analysis primarily restrict payment for medically necessary treatment of non-dental conditions only when such treatment can be provided at no cost by someone else, is exorbitantly expensive and has little chance of effectiveness (as in certain organ transplants) or is dangerous or experimental. See M152.1, M511, and M613 - 618.

3. The regulations give as an example a patient with a history of repeated heart attacks who must have all his other teeth extracted.